



EPD WAIVER PROGRAM PARTICIPANT HANDBOOK

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**District of Columbia Department of Health Care
Finance**

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*A User Guide for
the Elderly &
Persons with
Physical
Disabilities
(EPD) Waiver
Program*

EPD Waiver Participant Handbook

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Notice of Non-Discrimination

The District of Columbia Department of Health Care Finance does not discriminate on the basis of actual or perceived: race, color, religion, national origin, sex, age, marital status, personal appearance, sexual orientation, gender identity or expression, familial status, family responsibilities, matriculation, political affiliation, genetic information, disability, source of income and place of residence or business. Sexual harassment is a form of discrimination which is prohibited by Title VII of the Civil Rights Act of 1964. In addition, harassment based on any of the above protected categories is prohibited by the Act. Discrimination in violation of the Act will not be tolerated. Violators are subjected to disciplinary action.

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DHCF Director's Welcome Letter

Dear EPD Waiver Participant,

Welcome to the DC Medicaid Elderly and Persons with Disabilities (EPD) Waiver program for Home and Community-Based Services (HBCS)!

The mission of the Department of Health Care Finance (DHCF) is to improve health outcomes by providing access to comprehensive, cost-effective and quality healthcare services for the residents of the District of Columbia.

In the District of Columbia, the health of our residents is a top priority. Through a combination of health programs, DC Government provides health insurance to approximately 35% of District residents. The largest of these programs is the Medicaid program, which is offered to qualified District residents. The EPD Waiver program is a partnership program, offered in cooperation with the Federal government.

Inside the EPD Waiver Participant Handbook you will find important information such as:

- Description and purpose of the EPD Waiver
- Description of services offered under the EPD Waiver program
- Instructions on how to access EPD Waiver services
- Description of participant's rights and responsibilities

Sincerely,

Wayne Turnage, Director
Department of Health Care Finance

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Introduction

The EPD Waiver Participant Handbook serves as a reference guide on what you need to know about EPD Waiver services including a description of the EPD Waiver services, your rights and responsibilities as a Medicaid EPD Waiver participant, how to file a complaint, a grievance, an appeal or a Fair Hearing.

The Department of Health Care Finance, the District of Columbia's Medicaid agency, wants EPD Waiver participants to understand the EPD Waiver process, how to access the EPD Waiver program, what to do if things do not go as planned, and how to be your own best advocate.

EPD Waiver Participant's Rights and Responsibilities

Whenever you receive Medicaid services, including EPD Waiver services, **you have a right to:**

- Be treated with respect and dignity
- Know that when you talk with your doctors and other providers, the conversation is private
- Have your illness or treatment explained to you in a language that you can understand
- Receive free interpretation and translation services if you need them
- Receive or refuse oral translation services
- Participate in decisions about your care
- Receive a full, clear and understandable explanation of treatment options and risks of each option so you can make an informed decision
- Refuse treatment or care
- Be free of physical and chemical restraints except in emergency situations
- Be able to see your medical records and to request them to be corrected if they are wrong
- Choose a primary care provider who is certified to participate in DC Medicaid

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- Request a Fair Hearing if you believe Medicaid was wrong in denying, reducing, suspending or stopping a service or benefit
- Have an opportunity to speak with an attorney for a Fair Hearing
- Obtain medical care without unnecessary delay
- Develop advance directives to choose to have, not to have, or not to continue any life-sustaining treatment
- Receive a copy of this EPD Waiver Participant Handbook
- Get an explanation of prior authorization procedures
- Receive information about certified Medicaid service providers, healthcare workers, Medicaid-funded facilities and your rights and responsibilities as a Medicaid EPD Waiver program participant
- Make recommendations about DHCF's member rights and responsibilities policy
- Have knowledge of available selections of providers to participate in your care planning from admission to discharge, and to be informed in a reasonable time of anticipated discharge and/or transfer of services

You are responsible for:

- Participating in a case management assessment with your case manager at least once a month and as necessary
- Treating all individuals that provide your care with dignity and respect
- Following the rules of DC Medicaid and the EPD Waiver program
- Following instructions you receive from your doctors and other medical providers
- Going to appointments you schedule and arriving to the appointment on time
- Asking for clarification if you do not understand your doctor's instructions
- Going to the Emergency Room (ER) only if you have a medical emergency
- Trying to understand your health issues and participating in developing treatment goals
- Helping your doctor in getting medical records from providers who have treated you in the past
- Telling Medicaid if you were injured as the result of an accident

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- Reporting to the Economic Security Administration (ESA) and your healthcare providers if you or a family member have other health insurance. It is okay to have other health insurance with Medicaid, but it is important to let ESA know you have it
- Telling ESA if you change your address, name or other important information
- Notifying your provider in advance if you are not able to make scheduled appointments

If You Do Not Hear or Speak English Well

You have the right to an interpreter if you do not speak English very well, or if you are deaf or hearing impaired.

When you call to schedule an appointment with your case manager, home health agency, doctor or other healthcare provider, tell the provider's office that you need an interpreter for your appointment and ask if there is enough time before the appointment to get interpreter services. The provider's office will request an interpreter for you or make sure an interpreter is available on the telephone during your appointment. You will not be charged for this service.

If you ask for an interpreter and do not get one, please contact the Office of the Health Care Ombudsman and Bill of Rights (OHCO) at 202-724-7491. The Ombudsman provides advocacy to DC residents as needed. In addition, if you need services and are denied, you may contact the Office of Health Care Ombudsman for assistance.

Office of the Health Care Ombudsman (OHCO)

The job of the Long Term Care Ombudsman is to advocate for and support quality of care for residents of the District of Columbia. The Ombudsman is selected to investigate and resolve complaints made by DC residents against officials, government agencies or community organizations and other agents. The Long Term Care Ombudsman program is government-run and available to residents of

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the District of Columbia, including those who live in nursing homes, assisted living facilities and adult care facilities. It is also available to DC residents receiving health and social care services in home and community-based settings.

The District of Columbia's Office of the Health Care Ombudsman and Bill of Rights is available to:

- Help you understand your healthcare rights and responsibilities
- Help you solve problems with healthcare coverage, access to healthcare, and issues regarding healthcare bills
- Listen to you and/or your authorized representative, and support you until your healthcare needs are addressed
- Guide you towards the appropriate private and government agencies when needed
- Help you in the appeals process
- Track health and social care problems and report patterns to help fix what is causing those problems

The Ombudsman is an important source of help for any Medicaid participant. In fact, the Ombudsman can help any DC resident with health insurance issues, including people with Medicare, private health insurance or other types of health insurance. The Ombudsman's office has friendly and helpful staff who want to help you get the healthcare you need.

You can contact the Office of the Health Care Ombudsman and Bill of Rights at (202) 724-7491. You can also visit their website at:

<http://healthcareombudsman.dc.gov> for more information.

Long Term Services and Supports (LTSS)

Long term services and supports are a variety of healthcare services and resources available to people who are elderly, people with a chronic illness or people with a disability. Long term services and supports are designed to help individuals meet

health, social and personal care needs. Most long term services and supports assist people with activities of daily living (ADLs) such as dressing, bathing, grooming and using the bathroom. Long term services and supports can be provided in home and community-based settings, in a nursing home or other facility. A person may need long term services and supports for a period of time such as after an acute illness, hospitalization or admission to a nursing facility, and may require LTSS over several months or years.

Medicaid

Medicaid began in 1965 as Title XIX of the Social Security Act and was created to provide medical assistance for certain individuals (persons 21 years of age or younger, age 65 and older, blind or disabled persons, and/or pregnant women) with low income and very few resources. Specific income and resource requirements must be met in order to be eligible for Medicaid. If you are receiving Supplemental Security Income (SSI) you likely qualify for Medicaid. Otherwise, you may apply for DC Medicaid to be considered for Medicaid insurance. Your income and resources as well as your medical needs will be reviewed to determine eligibility.

In the District of Columbia, Medicaid is administered by the District of Columbia Government's Department of Health Care Finance. The Department of Health Care Finance is also known as DC Medicaid.

Some Services Covered by Medicaid

- Hospital stays (inpatient hospital services)
- Clinical visits/doctor visits/medical appointments/outpatient services
- Some prescription drugs
- Some dental services
- Some vision and hearing services
- Mental healthcare services
- Rehabilitation services
- Hospice services

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- Ambulance services
- Transportation
- Long term care services
 - Nursing home care
 - Home and Community-Based Services, including Medicaid Waivers (EPD Waiver, IDD Waiver)

What is a Medicaid Waiver?

A Medicaid waiver is designed by a State to cover home and community-based services (HCBS) as another choice to receive care in places other than institutional settings such as a nursing home. To become a Waiver participant a person must qualify by meeting certain criteria (see page 14).

In the past, Medicaid funds were only available for services provided in institutions. As individuals began to ask for more flexible care options, Congress agreed that people could benefit from staying in their natural homes, and allowed home and community-based services as other options to institutional care. One main requirement for the Waiver program is that the cost for the individual to receive care in their home (or other location in the community) should not cost more than what it costs to receive care in a nursing home. This means that the cost for receiving care in your home must be the same or less than the cost of receiving care in a nursing facility.

The Waiver is a choice program. The Waiver participant and/or authorized representative has the ability to select the providers of their choice. This is called “freedom of choice.” Freedom of choice means participants have the option to select whether to receive healthcare services in their home (or other location in the community), or in an institution such as a nursing home. Freedom of choice also means that a participant may choose any Medicaid-certified provider for any service for which he/she is eligible.

Every state that operates a Waiver program must meet certain Federal rules and regulations to receive funding from the Federal government. These rules include how the District will:

- Assure the health and well-being of individuals enrolled in the Waiver program;
- Assure that all Medicaid service providers are qualified providers. Providers must meet District and Federal provider requirements and also follow waiver requirements;
- Assure that participants have a choice of who will provide their Waiver services;
- Assure that the participant is involved in the development of his/her person-centered service plans;
- Assure that participants enrolled in the Waiver meet the proper level of care; and
- Assure that the cost of services approved and provided are not more than the cost of a nursing home or institutional care on a per person basis.

What is the EPD Waiver Program?

The EPD Waiver program is a home and community-based services (HCBS) waiver designed to provide older adults (65 years of age and older) and persons with physical disabilities (between 18 and 64 years of age) with quality healthcare services in the place where they live.

The District of Columbia's EPD Waiver application is renewed by the Center for Medicaid and Medicare Services (CMS) every five (5) years. The current EPD Waiver was approved in April 2017. The maximum number of participants established for each Waiver Year (WY) is listed below. Participants are enrolled in the EPD Waiver on a first-come, first-served basis. Once the program is at the maximum number (also known as *capacity*), a waiting list is established.

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Waiver Year	Unduplicated Number of Participants
Year 1	5160
Year 2	5260
Year 3	5360
Year 4	5460
Year 5	5560

Each year DHCF (DC Medicaid) receives funding from the Federal government to pay for the Waiver services you receive. The Medicaid agency has agreements with qualified community providers who give you the services you need.

EPD Waiver Eligibility Requirements

To receive services under the EPD Waiver program, you must first complete an application and have an eligibility review for enrollment.

You must meet the following EPD Waiver program eligibility requirements:

- Be a District of Columbia resident;
- Be a U.S. citizen or qualified resident;
- Be DC Medicaid eligible with income of less than 300% of SSI (for 2018, that is \$2,250 per month or \$27,000 per year);
- Have no more than \$4,000 in countable assets;
- Require assistance with activities of daily living (such as dressing, using the bathroom, and grooming)
- Be elderly (65 years of age or older), or 18 to 64 years of age and diagnosed by as physician as having a physical disability;
- Meet a nursing home level of care (LOC);
- Be Medicaid eligible and maintain your Medicaid eligibility (More information on this can be found on the DC Department of Human Services website (<http://dhs.dc.gov>) at the Economic Security Administration (ESA)); and

- Choose home and community-based services rather than institutional care. Institutional care would include services provided through the District's nursing home and specialty hospital programs.

EPD Waiver Services

Waiver services do not replace family systems and/or other community systems. Waiver services are designed to add to the participant's family and social supports. Here is a list of currently available services through the EPD Waiver:

1. Adult Day Health Program (ADHP)
2. Assisted Living Facilities (ALF)
3. Case Management Services
4. Chore Aide Services
5. Community Transition Services
6. Environmental Accessibility Adaptation Services (EAA)
7. Homemaker Services
8. Occupational Therapy (OT)
9. Participant-Directed Services (Services My Way)
10. Personal Care Aide Services (PCA)
11. Personal Emergency Response Services (PERS)
12. Physical Therapy (PT)
13. Respite Services

Adult Day Health Program (ADHP)

ADHP offers a range of therapeutic, rehabilitative and support services. These services include nursing and rehabilitation services, assistance with life activities, social work services, dietary services and transportation, which is provided for parts of the day during the week. ADHP services are designed to support older adults and individuals with physical disabilities to live in the community by offering non-residential medical supports and supervised, therapeutic activities in a combined setting. ADHP services are designed to encourage opportunities for community involvement.

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Roles: ADHPs link participants with their community. Onsite, you can typically find an activities coordinator, registered nurse, social service professional, doctor, dietician, and other support services staff. For additional help, ADHPs have support staff available.

- The **activities coordinator** is responsible for planning educational, recreational and community integration activities and events. As a participant, you have the freedom to choose the activities that you want.
- The **registered nurse** monitors the medical needs of participants, supervises nursing services and gives participants their medication. Nurses at ADHP sites provide education that focuses on improving the health, safety and wellness of participants.
- The **social service professional** assists in developing activities that are designed to improve a participant's well-being. A social service professional (often a social worker) is available for individual and group counseling. A social service professional is also responsible for letting participants know about helpful community resources as needed.
- A **Medical Director** is a doctor who is responsible for directing and supervising medical care of ADHP participants. The medical director will consult with a participant's primary care physician when necessary.
- A **dietician and/or nutritionist** monitors the daily food requirements for each ADHP participant and develops the menus for meals and snacks that are provided. The dietician and/or nutritionist are available to offer counseling and education regarding nutrition.

Participants who are in attendance for less than three (3) hours receive a minimum of one (1) meal **or** one (1) snack.

Participants who are in attendance between three (3) to four (4) hours receive one (1) meal **and** one (1) snack.

Participants who are in attendance for a total of five to eight hours per day receive a minimum of two meals **and** two snacks, **or** one meal and two snacks. See the below meals/snacks summary:

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Time of Attendance During One Day	Number of Meals and Snacks	Portion of Nutritional Daily Allowance
Less than 3 hours	1 meal or 1 snack	1/4
Between 3-4 hours	1 meal and 1 snack	1/3
Between 5-8 hours	2 meals and 2 snacks or 1 meal and 2 snacks	1/2

Assisted Living Facilities (ALF)

An assisted living facility (ALF) is a licensed facility where participants can live and receive the services they need to be as independent as possible. The person's choice for independence must also protect the safety of the participant and other persons who live at the facility.

An assisted living facility (ALF) is responsible for providing supportive living services that may include the following:

- Eating and food preparation
- Personal hygiene
- Dressing
- Supervising medication administration
- Help with movement or getting around
- Supported decision-making
- Opportunities to engage in community life

ALFs provide a wide range of professional services such as:

- Dentistry
- Education
- Nutrition
- Nursing
- Occupational therapy
- Physical therapy
- Psychology
- Social work
- Speech-language and hearing therapies

Case Management Services

Case management is the organization of services on behalf of the participant. Case management is a shared process of conducting assessments, planning, counseling

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and promoting the options and services that best meet the participant's (and family's) total health and social care needs. Case management services are the foundation of the EPD Waiver program and therefore, regular communication and visits are required to make sure services are fully coordinated.

A case manager is a licensed care professional and who meets the conflict-free case management standards as required by District and federal law. Case managers help EPD waiver participants in many ways: getting quality services that support choice, independence, dignity, and privacy, and by coordinating services with the participant and his/her family members, their social support system, other waiver providers, and their medical personnel. At least one (1) face-to-face assessment case manager visit is required each month. However, if more visits are needed, case managers may make additional visits.

Case managers coordinate EPD Waiver services with other Medicaid services, such transportation services, Medicaid State Plan services, doctor visits and nursing home care. Case managers also provide referrals to non-Medicaid programs and other community resources when additional needs are identified. Case managers do not provide medical, financial, or legal services. A case manager meets with participants and other providers to determine goals and progress, identify and resolve problems, and make referrals or connections to community resources.

Keeping a supportive relationship with a case manager is a very important part of a participant's responsibility to ensure their quality of care and overall health. If a participant does not make himself/herself available for case management services, EPD Waiver services can be ended.

After a person is accepted into the EPD Waiver program, a case manager is assigned and then makes a visit to evaluate the participant's current and historical medical, social and functional status and to determine care needs. As part of this process, the case manager writes a person-centered service plan together with the participant (and anyone the participant identifies) that lists the participant's goals, wishes, and choices. The case manager makes monthly face-to-face assessment

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visits in the participant's home or care environment. A case manager will also assess if different, additional or fewer services are needed, and offer additional community connections/referrals if they are needed.

Chore Aide Services

Chore aide services are heavy-duty housecleaning activities for short amounts of time that allow the participant's home to be made clean and safe in a manner that can be continued by regular housekeeping.

A chore aide provides one-time, non-medical household tasks, such as washing floors, windows and walls, trash removal, and moving furniture to provide safe access. Chore aides **do not** provide hands-on personal care, meal preparation, grocery shopping or respite services.

Community Transition Services

Community transition services are available to EPD Waiver participants who are changing from a nursing facility or other long-term care facility to a more integrated, community-based setting. Community transition services include one-time household setup expenses that are needed to allow an individual to establish a basic household. In addition to this, community transition services help to inform participants of their long-term care options and rights when returning to the community. Community transition funds must be identified in the person-centered service plan, approved before the start of services, and used for up to one hundred and twenty (120) days before discharge and up to six (6) months after discharge from an institution or long-term care facility.

A community transition service representative is a licensed professional who helps to coordinate all health and social care services to help the participant make a smooth transfer back into their home or community-based setting.

Environmental Accessibility Adaptation Services (EAA)

EAA services allow for the physical modifications (such as ramps, stairlifts, and grab bars) to a participant's home that are necessary to ensure the health, safety and wellness of the participant. EAA **does not** include installation of carpeting,

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roof repair or air conditioning. Participants must first apply through the Handicap Accessibility Improvement Program (HAIP) of the DC Department of Housing and Community Development (202-442-7200).

The EAA process includes but is not limited to the following:

1. Meeting (by telephone or in person) with the participant seeking EAA services, the case manager, and support team;
2. Conducting an in-person assessment to address the participant's accessibility needs and decide what modifications will be needed to his or her home; and
3. Drafting a written report which includes a summary of the in-person assessment and lists recommendations of the home modifications based upon the participant's needs.

No EAA services will be approved or reimbursed by Medicaid for a participant seeking EAA services who qualifies for the Handicap Accessibility Improvement Program (HAIP) as described above. Only documented and certified homeowners qualify for HAIP, which means that an applicant who is a renter cannot apply for HAIP.

Before starting EAA services, the case manager must help the participant receive an evaluation or home inspection from a Certified Third-Party Construction Inspector or a licensed contractor. The case manager can work with the participant throughout the entire process of applying for the EAA benefit.

Homemaker Services

Homemaker services provide general household activities such as meal preparation, housekeeping and running errands. Homemakers **do not** provide any hands-on personal care. Allowable services include grocery shopping, meal preparation, limited general housecleaning, providing escort services (not transportation) for medical appointments, and running care-related errands such as picking up medication or mailing utility payments.

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Occupational Therapy (OT)

Occupational therapy is the use of assessment and treatment to help people to do the things they want and need to do through the therapeutic use of daily activities (occupations). Occupational therapists help people of all ages to live life to its fullest by helping them promote health and prevent (or live better with) injury, illness or disability.

Participant-Directed Services (PDS; also called *Services My Way*)

The Participant-Directed Services program, also known as *Services My Way*, allows EPD Waiver participants who live in at home the ability to have more choice and control of their Medicaid long term care services. Participants enrolled in *Services My Way* have the option to self-direct two (2) specific PDS services:

1. *Participant-Directed Community Supports* are similar to Personal Care Aide (PCA) services. When enrolled in this program, the participant or his/her authorized representative is the common-law employer of their Participant-Directed Worker (PDW). A PDW is the person employed by the common law employer (or beneficiary participant) to provide personal care aide services.
2. *Individual-Directed Goods and Services* are services, equipment or supplies not otherwise provided through the EPD Waiver or State Plan programs. The requested goods or services **MUST** address an identified need in the participant's person-centered service plan (PCSP) and meet the following requirements:
 - 1) Decrease the need for other Medicaid services; and/or
 - 2) Encourage community integration; and/or
 - 3) Increase the participant's safety in the home environment.

Again, *Services My Way* is only available to active EPD Waiver participants.

The first step to enroll in *Services My Way* is to meet with the participant's EPD Waiver case manager who will amend the PCSP to include *Services My Way*. The participant will then be contacted by the Medicaid contractor responsible for operations of the program to provide a complete orientation and training and to begin the enrollment process.

Personal Care Aide (PCA) Services

PCA services are hands-on care for daily activities such as assistance with bathing, grooming, dressing, walking, toileting, eating, and medication reminders. PCA services also include assistance with range of motion exercises as well as meal preparation that follow any identified dietary guidelines.

A PCA follows the plan of care that is decided by the participant, the participant's healthcare team (registered nurse, physician, dietician, etc.), and any friends and/or family identified by the participant. A PCA can perform the following types of services: personal care activities (bathing, grooming, and toileting), changing urinary drainage bags, assisting with range of motion exercises, reminding the participant to take medication (please note however that PCAs **do not** administer medication), reading and recording temperature and pulse, documenting and reporting activities of care or emergency situations to the nurse and/or case manager, preparing meals according to dietary guidelines, assisting with eating or feeding, completing tasks to keep the living area safe, going with the participant to his/her medical appointments, grocery shopping and picking up prescriptions, and going with the participant to recreational activities that support PCSP goals.

Personal Emergency Response System (PERS)

PERS is an electronic system including a device that allows a person to call for help from an emergency response team or service provider when help is needed. In order to be approved for PERS, the individual has to be able to understand how to use the system, and show that they know how to use it properly.

Personal Emergency Responses System (PERS) devices are used to alert emergency services in case of an emergency. A PERS provider provides twenty-four (24) hour services for participants, seven days a week.

Physical Therapy (PT)

Physical therapy can help a patient regain movement or strength after an injury or illness through the use of exercise and/or equipment. Physical therapy can also help to improve balance and prevent falls.

A licensed physical therapist can provide therapy services in an individual's home or day program setting to make the most of their independence, prevent further disability and maintain health and functional status. PT services are also designed to treat the identified physical injury or weakness, or to help reduce pain associated with movement.

Respite Services

Respite services are very similar to PCA services. Respite services allow temporary relief to a primary caregiver by providing temporary PCA services for activities of daily living in the caregiver's absence. Respite can be provided hourly or daily in the home environment.

A Waiver participant may be assigned a respite aide based on his/her person-centered service plan. A respite aide must meet the same or similar standards as a PCA.

How to Enroll in the EPD Waiver

The EPD Waiver enrollment process for new applicants is completed through the Aging and Disability Resource Center (ADRC) at the District of Columbia's Office on Aging (DCOA). For new – or initial – enrollment the ADRC staff will work directly with the individual until EPD Waiver eligibility is determined by the Economic Security Administration (ESA).

To begin:

The applicant must first call the ADRC at 202-724-5626 to request long term care services and supports. The ADRC's Information and Referral and Assistance Unit (I&R/A) will complete intake details and make a referral for the EPD Waiver. The I&R/A Unit will then mail an EPD Waiver self-service application packet to the new applicant.

The applicant can also get the self-service application online by visiting <https://dcoa.dc.gov/EPDWaiverProgram>.

The application packet gives instructions on how to apply to the EPD Waiver program. The ADRC will follow up on all referrals within 10 business days. Individuals can complete and submit the application packet to the ADRC or request a phone appointment, office visit or home visit by an ADRC staff member called a Medicaid Enrollment Specialist to assist with completing the EPD Waiver application.

EPD Waiver Application Packet Requirements*

1. Beneficiary Freedom of Choice, Rights and Responsibilities form
2. Attestation form with case management selections
3. Prescription Order Form (POF)
4. District of Columbia Long Term Care Medicaid Application
5. Proof of residency, i.e. utility bill, driver's license, or bank statement(s) (not required for current Medicaid recipients)
6. Proof of income and other supporting documentation (i.e. Social Security allocation letters, annuity letters)

7. Proof of assets (i.e. stocks and bonds, mortgage statement, property tax information, life insurance policy)
8. Proof of guardianship (if applicable)
9. Proof of Power of Attorney (if applicable)

**Additional requirements identified by ESA may be requested as necessary*

Level of Care Certification (LOC)

To receive long term services and supports (LTSS) through the Medicaid program, an individual must obtain a complete and Prescription Order Form (POF). A POF is an order by a doctor or Advanced Practice Registered Nurse (APRN) to request an assessment for long term care services. The doctor or APRN who completes and signs the POF must be a DC Medicaid-enrolled provider.

Eligibility for long term care services is based on a level of care (LOC) determination completed through a face-to-face assessment. The face-to-face assessment is conducted by a nurse who is a staff member with the District's LTSS Contractor, Liberty Healthcare Corporation.

Eligibility for the EPD Waiver program is determined by receipt of a score of nine (9) or higher on the level of care determination. A copy of the complete assessment can be provided to the participant upon request.

Financial Assessment – Economic Security Administration (ESA)

Once a complete EPD Waiver application is received and a LOC is determined, the ADRC sends the application to the Economic Security Administration (ESA) to determine financial eligibility for the EPD Waiver program. In order to receive LTSS through the EPD Waiver program, you must meet the LOC requirement (score a 9 or above) as well as the income and resources eligibility requirements for the EPD Waiver program.

To qualify, your gross monthly income must be at or below \$2250.00 for year 2018 and your total resources must be at or below \$4,000.00 for an individual or

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\$6000 for married couples. If your income is higher than \$2,250.00 a month, you are over the income limit for Medicaid EPD Waiver, but you may still qualify for Medicaid EPD Waiver by being placed on a Medically Needy Spend Down. ESA has forty-five (45) days to determine eligibility once a complete application is received by ESA.

Spend Down Medicaid is for individuals who have income over the Medicaid limit but also have high medical bills which they are responsible for paying. Most Medicaid eligibility groups may be eligible for Medicaid through the Spend Down process with some exceptions like adults without dependent children (childless adults) and Qualified Medicare Beneficiaries.

A Spend Down amount is met by adding up medical costs. Payments for medical care, supplies and prescriptions may be included in the spend down amount. The participant will be eligible for Medicaid on the first of the month that they meet his/her spend down amount. Long Term Care Medicaid eligibility under Spend Down is a six-month period, and participants will be eligible starting the first day of the month in which they meet his/her spend down amount through the rest of the six-month period.

Case Management Agency Provider Selection

ESA will send a notice to the applicant and to the ADRC, letting the applicant know if they have been approved or denied. If the application is approved, the ADRC reaches out to the selected case management agency (as noted on the case management selection form) of the applicant's EPD Waiver enrollment, and the new applicant is transferred to the case management agency that they selected. The new applicant at this point becomes an EPD Waiver participant. The transfer from the ADRC to the case management agency is called a case transfer.

The case management agency contacts the EPD Waiver participant within 48 hours (2 business days) of the case transfer to the case management agency.

Developing the Person-Centered Service Plan (PCSP) – Case

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Management Agency (CMA)

Within 48 hours (2 business days) of accepting the case, the CMA contacts the applicant to organize an intake and face-to-face visit. A case manager is assigned to the participant. The case manager completes a person-centered service plan (PCSP) with the EPD Waiver participant and any other persons who he/she would like to participate in their care. The PCSP should be completed within ten (10) days of the CMA accepting the case.

The PCSP serves as a road map for achieving goals and identifies the services and supports the participant needs in order to meet those goals and preferences.

Recertification Every 12 Months:

How to Make Sure EPD Waiver Enrollment Continues

- The participant will receive notification for Medicaid EPD Waiver re-enrollment from ESA at least 90 days before the current eligibility ends
- The participant must contact the case manager as soon as the ninety-day notice from ESA is received
- The case manager will assist with getting all the information needed for re-enrollment, such as:
 - Medical appointment and/or medical assessments to complete the POF
 - Case Manager attestation
 - Income verification
 - Asset verification
 - Completed and signed re-enrollment application
 - Medicaid bills

How to Change, Transfer, Discharge/Suspend, or Stop Services

The case manager will coordinate all requests to start, change, stop, transfer or discharge services.

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A change request is required when a participant needs service(s) to be increased, decreased, stopped or transferred. This will require the participant or authorized representative to contact the case manager, informing them of the change of care needed. The case manager will update the person-centered service plan to reflect the change and submit it to the Department of Health Care Finance for approval.

How to Request a Transfer

A participant can change service providers at any time if he/she is not happy with the service provider(s). This is called a “transfer.” A transfer is changing from one provider to another.

A transfer takes place upon the participant’s and/or authorized representative’s request. A transfer may also take place when the provider no longer offers services. Here are the steps that need to be followed when requesting a transfer:

1. Contact the case manager or case management agency.
2. The case manager will ask for the participant’s choice of a new provider.
The participant may also request assistance from the case manager to find a different provider.
3. The case manager will revise the person-centered service plan to reflect the request for transfer.
4. The case manager is responsible for coordinating a transfer to the agency of the participant’s choice within 72 hours of submitting a completed transfer form to DHCF.

Placing Services on Hold

When an applicant is admitted to a hospital or nursing facility, EPD Waiver services are placed on hold. The case manager will coordinate care while the participant is in a facility up to 120 days from the first day of admission to the facility to assist with the transition back to the community. If the participant does not return to the community within 120 days, the participant will be discharged

from the EPD Waiver and will need to re-enroll by applying through the Aging and Disability Resource Center.

Discharge from a Provider Agency

EPD service providers can discharge a participant from their agency under certain conditions. Before the provider discharges a participant, the provider must show they attempted to meet with the participant to resolve the outstanding problems and make sure the participant's health is not threatened during a discharge. The provider must arrange for alternative services before the discharge is effective and notify the Department of Health Care Finance. The provider must give a thirty (30) day notice. The provider is required to continue to provide services until the participant has selected a new provider within the thirty (30) day notice period. The notice shall include but is not limited to the following:

- Decision to terminate the services
- Reason for termination of services
- Copy of the EPD Waiver standards that support the termination decision
- Copy of the directory of other the Waiver providers
- Information on participant rights to appeal the decision and instructions for obtaining a Fair Hearing or filing a complaint

Reasons for Disenrollment from the EPD Waiver Program

The participant may be disenrolled from the EPD Waiver program if he/she:

- No longer meets the financial eligibility requirements
- No longer meets the required level of care as supported by the assessment tool
- Passes away
- Moves out of the District of Columbia
- Remains institutionalized for a period that is expected to exceed one hundred and twenty (120) consecutive days
- Requests disenrollment, in writing, from the EPD Waiver

- Failed to provide the case management agency with recertification documents or cooperate with the case manager to ensure that a level of care assessment is completed

Freedom of Choice

Once the eligibility requirements of the EPD Waiver program are met, participants have the right to decide whether they want to receive services in the community (where he/she lives) or in an institutional setting, such as a nursing home. The right to select where to receive care and which providers to use is called Freedom of Choice (FOC).

The Freedom of Choice document is one of the papers signed when the application is completed. The EPD Waiver rules require a signed FOC document at the beginning of the EPD Waiver enrollment to clearly show that the participant has chosen to either participate in the EPD Waiver program or receive institutional care such as nursing home care.

Freedom of Choice has three different components:

1. To choose whether to participate in the EPD Waiver program or receive institutional care (such as nursing home care)
2. To choose a provider from the selections of certified Medicaid providers
3. To choose from the range of services, based on the level of care needs documented in a person-centered service plan

If the rules for Freedom of Choice are not followed by care professionals, a participant and/or an authorized representative can file a complaint or an appeal.

Appeals

An appeal is a request for a review of an action (usually a negative action) taken against a participant. An appeal can fall under two categories:

Fair Hearing: The fair hearing process provides an opportunity to appeal a previous decision and receive an impartial review about EPD Waiver

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services. The fair hearing is conducted at the DC Office of Administrative Hearings located at 441 4th Street, Judiciary Square, Washington DC, 20001.

Reconsideration: If the participant believes that care needs were not properly or fairly assessed, a participant may file for a reconsideration. The reconsideration process allows for an internal administrative review conducted by DHCF and the State Medicaid Director, and involves a review of the participant's health and social care needs as well as a review of past assessments.

Complaints and Grievances

A complaint is an expression of dissatisfaction. A complaint or grievance may be about the quality of care, service, treatment or benefit, or about a provider or caregiver, etc.

The case manager, the Department of Health Care Finance and/or the Ombudsman can assist to file a complaint about the care, services or benefits received from an EPD Waiver provider. The participant has the right to make a complaint, file a grievance or file an appeal. The participant may file a complaint as described below:

Complaints to Your Provider

When a participant thinks he/she is not getting the service(s) or the care that is in the person-centered service plan (PCSP), call the case management agency. The case manager is an important resource to help resolve care concerns. Here are some helpful steps to resolve situations quickly:

1. Speak with the case manager. Provide him/her with the participant's name and telephone number, as well as a description of what is wrong.
2. If the case manager is of concern, call the provider agency and ask to speak to the provider agency director or administrative staff, and remember to tell him/her the participant's name and telephone number, as well as a description of what is wrong. For instance, what does a participant do when the PCA does not arrive or arrives very late to the home? If there is a

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complaint about a care provider (PCA, nurse, etc.), the participant should contact the provider agency with concerns. If the concerns are not addressed appropriately, the participant may contact DHCF/DC Medicaid.

Complaints to DHCF (DC Medicaid)

DHCF is available to help EPD Waiver program participants and answer questions, address concerns, make sure needs are met and participants' rights are respected.

To submit a complaint to DHCF, call the Long Term Care Administration Hotline at (202) 442-9533. Remember to give the participant's name and telephone number, as well as a description of the complaint.

The participant or someone representing the participant may also submit a complaint by email to: DHCFLTCAComplaints@dc.gov

Lastly, the participant may also contact the Office of Health Care Ombudsman and Bill of Rights for assistance.

Complaints to the DC Health Care Ombudsman

The mission of the Office of Health Care Ombudsman and Bill of Rights is to guide, support and help people navigate through the healthcare system by helping them understand their healthcare coverage, assist in appealing health insurance decisions, including public healthcare programs, i.e., Medicaid, Medicare, Tri-Care and assisting District residents and those who have claims, medical procedures and prescriptions that have been denied by insurance companies that are regulated by the District of Columbia Department of Insurance, Securities and Banking. To contact the Office of Health Care Ombudsman and Bill of Rights, call (202) 724-7491, email healthcareombudsman@dc.gov, or fax 202-478-1397.

Contact Information for Appeals and Complaints

Medicaid, District of Columbia, Department of Health Care Finance
441 4th Street, NW, Suite 900 South Washington, DC 20001
Telephone Number: (202) 442-5988
Email: DHCFLTCAComplaints@dc.gov

Office of the Health Care Ombudsman and Bill of Rights
441 4th Street, NW, Suite 900 South Washington, DC 20001
Telephone Number: (202) 724-7491
Email: healthcareombudsman@dc.gov

You have a right to request a Fair Hearing with the DC Office of Administrative Hearings and you may call or make your request in writing to:
DC Office of Administrative Hearings
441 4th Street, NW, Suite 450 North
Washington, DC 20001
Telephone Number: 202-442-9094

Your Rights

During the appeals (Fair Hearings and Reconsideration) and complaints/grievances processes:

- You have the right to a Fair Hearing and may request a hearing no more than ninety (90) days from the postmark of the letter notifying you of the action taken by the DC Government and/or EPD Waiver providers
- You have the right to keep receiving a benefit while your Fair Hearing is being reviewed. To keep your benefit during a Fair Hearing, you must request a Fair Hearing before the 30-day notice ends
- You have the right to request a Reconsideration within 21 days of the date noted on the notice
- You have the right to have someone from the DC Health Care Ombudsman help you through the grievance process
- You have a right to represent yourself or be represented by your family caregiver, lawyer or other representative of your choice
- You have a right to have accommodations made for any special healthcare needs you have
- You have a right to TTY/TDD capabilities and services for the visually impaired
- You have a right to translation services and/or an interpreter

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- You have a right to see all documents related to your appeal (Fair Hearing or Reconsideration) or your complaint/grievance

Advance Directives

- An advance directive, also known as a living will, is a legal document that gives instructions to your family and health care providers about what health care you want in case you become so hurt or sick that you cannot speak for yourself. It lets you decide what kind of care you want in different situations and it assigns someone you know to act for you if you cannot talk. You can cancel an advance directive at any time.
- Developing an advance directive is responsible: it makes your healthcare wishes clear to your family, friends, and health care professionals, and avoids confusion in the future.
- One source of help in developing an advance directive is the Neighborhood Legal Services Program. Call (202) 269-5100 or visit their website at: www.nlsp.org. An advance directive is a legal document, and needs to be signed by witnesses to make sure you wanted it.
- If you develop an advance directive, give it to your doctor so it is a part of your medical record.

Other Important Things to Know

If You Get a Bill for a Covered Medicaid Service:

When proper identification (Medicaid ID card) is presented at health care appointments, EPD Waiver program participants should not be billed for the care received. Remember to always take your Medicaid ID card to all healthcare appointments. If you do get a bill for medical care while you are participating in the EPD Waiver program, contact the provider and remind them that they must bill Medicaid for the services they provided you. If you have problems getting the providers to respond, you may contact the Office of the Health Care Ombudsman and Bill of Rights at (202) 724-7491.

If You Have Other Insurance

Medicaid is always the payer of last resort. This means that if a participant has any other insurance, that insurance will be billed *first* for the services received. Medicaid will then be billed for the remaining balance. Please let the case manager know if the participant has any other type of insurance, including Medicare.

If a Participant Has Both Medicaid and Medicare

A participant is considered to be “dually enrolled” when he/she has both Medicare and Medicaid. Please also be sure to inform the case manager of your Medicare number.

When a Participant Moves or Any Other Demographic Information Has Changed

The participant must inform the case manager and/or ESA of any new address, name change and/or other demographic changes.

Important Notices that Might Be Received

Participants may get important information from DC Medicaid or its designees at any of the following times:

- When it is time to re-enroll and update eligibility for the EPD Waiver program
- When more/other information is required to help with a participant’s Medicaid application. For instance, ESA may require more documents to review for eligibility to enroll in the Medicaid EPD Waiver program
- When eligibility to participate in the EPD Waiver program has been approved
- Once services are approved for the EPD Waiver program, and the participant can begin receiving services

ADDITIONAL INFORMATION

Notice of Privacy Practices

This Notice is Effective as of April 14, 2003

ENGLISH

'If you do not speak and/or read English, please call (202) 442-5988 between 9:00 a.m. and 4:00 p.m. A representative will assist you.'

SPANISH

'Si no habla o lee inglés, llame al (202) 442-5988 entre las 9:00 a.m. y las 4:00 p.m. Un representante se complacerá en asistirle.'

AMHARIC

እርስዎ መናገር እና / ወይም እንግሊዝኛ የማይናገሩ ከሆኑ, ከምሽት 9 00 እስከ 4 00 ፒ.ኤም. (202) 442-5988 ይደውሉ. ተወካይ እርሶን ይደግፋል. '

VIETNAMESE

'Nếu bạn không nói và/hoặc đọc tiếng Anh, xin gọi (202) 442-5988 từ 9 giờ 00 sáng đến 4 giờ 00 chiều. Sẽ có người đại diện giúp bạn.'

TRADITIONAL CHINESE

'如果您不能講和/或不能閱讀英語, 請在上午 9:00到下午 4:00之間給(202) 442-5988 打電話, 我們會有代表幫助您。'

KOREAN

'영어로 대화를 못하시거나 영어를 읽지 못하시는 경우, 오전 9시 00분에서 오후 4시 00분 사이에(202) 442-9533번으로 전화해 주시기 바랍니다. 담당 직원이 도와드립니다.'

**This Notice Describes How Protected Health Information about You May Be
Used and Disclosed
and How You Can Get Access to This Information.
Please Review This Notice Carefully.**

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The Department of Health Care Finance, or DHCF, keeps your protected health information (PHI) confidential. The Economic Security Administration (ESA) approved you for Medicaid. ESA then sent information about you to DHCF. DHCF uses this information to pay for your healthcare.

Your PHI includes your name, address, birth date, and phone number. It also includes your social security number, Medicare number (if any), and health insurance policy information. It may include information about your health condition.

The claims by health care providers include your diagnoses. The claims list your medical treatment and supplies. Claims also include physician's statements, x-rays, lab test results, and other diagnostics. Your PHI is this information too.

The law requires us to keep your PHI private. We must provide you with this Notice of our legal duties and privacy practices. The law requires DHCF to abide by this Notice.

Use of Your PHI

We use your PHI to allow a doctor, nurse, or other health care professional/provider to treat you. We allow a business office to process payment for your medical services with your PHI. Administrative personnel reviewing the quality of the care you receive use your PHI too. This notice also governs how DHCF and the ESA will use and disclose your health information to each other.

We may also use and/or disclose your PHI without your permission when permitted by law, examples of this are:

Treatment: To a health care provider to treat you. (EXAMPLE: DHCF may share your PHI with a clinical laboratory.)

Payment: To pay claims for services delivered to you. (EXAMPLE: DHCF shares your PHI with a claims processor. The contractor verifies that you received treatment.)

Health Care Operations: To perform health care operations including:

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- Determining health care quality
- Reviewing accreditation, certification, licensing and credentialing
- Conducting medical reviews, audits, and legal services
- Underwriting and other insurance functions
(EXAMPLE: DHCF sends your PHI to a quality review committee.)

Previous Provider: To your current or past health care provider.

Public Health and Benefit Activities: For the following kinds of public health/interest activities:

- For public health
- For healthcare oversight
- For research
- To coroners, medical examiners, funeral directors, and organ procurement organizations
- As authorized by DC workers' compensation laws

To Avoid Harm or Other Law Enforcement Activities: We may disclose your PHI:

- To stop a serious threat to health or safety
- In response to court/administrative orders
- To law enforcement officials
- To the military and intelligence activities
- To correctional institutions

Communication: To contact you personally to keep you informed. (For example, DHCF may send appointment reminders or information about other treatment opportunities to you.)

**Authorization for Other Uses and Disclosures of PHI
not Mentioned in this Notice:**

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DHCF will only use or disclose your PHI for purposes this notice mentions. DHCF will obtain your written approval for other uses and disclosures. You may take back your authorization in writing any time. You may contact the DHCF Privacy Officer at the address listed at the end of this notice.

Your Rights Regarding Your PHI:

You have the following rights with respect to your PHI. In writing, you may:

- Ask us to limit how your PHI is used or shared. We are not required to agree to your request. If we do agree, we will honor it.
- Ask DHCF to talk to you in a different manner.
- Generally, see and copy your PHI. You may ask that any refusal to do so be reviewed. You may be charged a reasonable fee for copies.
- Ask DHCF to change your PHI. We may not make your requested changes. If so, we will tell you why we cannot change your PHI. You may respond in writing to any denial. You may ask that both our denial and your response be added to your PHI.
- Get a list of certain companies that received your PHI from DHCF after April 14, 2003. This list will not include a list of disclosures made for treatment or payment. Nor will it include disclosures for healthcare operations, information you authorized us to provide, or government functions.
- Request a paper copy of this Notice of Privacy Practices.

Concerns or Complaints about the Use or Disclosure of Your PHI

For more information about our privacy practices, you may contact the Agency Privacy Officer or the District Privacy & Security Official at either of the following addresses.

DHCF Privacy Officer
DC Department of Health Care Finance
441 4th Street NW
9th Floor
Washington, DC 20001
Voice: (202) 442-5988

DC Private & Security Official
DC Office of Health Care Privacy and
Confidentiality
in the Office of the Attorney General
1350 Pennsylvania Ave NW, Suite 307
Washington, DC 20004

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Fax: (202) 442-4790
E-mail: dhcfprivacy@dc.gov
Fax: (202) 727-0246

Voice: (202) 727-8001
Fax: (202) 727-0246
E-mail: dcprivacy@dc.gov

You may also contact the Privacy Officer for additional copies of this notice. You have the right to complain to us. You may also complain to the U. S. Department of Health and Human Services. Complaints will not cause you any harm. To complain to us, please contact DHCF at either of the District offices (above). You also may send a written complaint to the Secretary of the U. S. Department of Health and Human Services at the following address:

Office for Civil Rights – Region III
U.S. Department of Health and Human Services
150 S. Independence Mall West, Suite 372
Public Ledger Building
Philadelphia, PA 19106-9111
Main number: (215) 861-4441
Hotline: (800) 368-1019
FAX: (215) 861-4431
TDD: (215) 861-4440
TTY: (886) 788-4989

Changes to this Notice

DHCF reserves the right to change the terms of this notice. If we change the terms of this notice, we will post a revised notice in the DHCF offices and on the DHCF, LTCA website. In addition, the current Notice of Privacy Practices will be posted on the Internet at <http://www.dhcf.dc.gov>.

E-mail: ocrmail@hhs.gov

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Important Contact Information

DHCF/DC Medicaid

Telephone: (202) 442-5988

Website: <http://dhcf.dc.gov>

Medicare

Telephone: (800) MEDICARE (1-800-633-4227)

DC Office on Aging, Aging and Disability Resource Center (ADRC)

Telephone: (202) 724-5622

TTY: (202) 724-8925

Website: <http://dcoa.dc.gov>

Economic Security Administration (ESA)

Telephone: (202) 576-8962

TTY: (202) 576-8962

Website: <http://dhs.dc.gov/node/117352>

Social Security Administration (SSA)

Telephone: (800) 772-1213

TTY: (800) 325-0778

Website: <http://www.ssa.gov>

DC Department of Health,

Health Regulation & Licensing Administration (HRLA)

Telephone: (202) 442-5833

Online complaint submission: http://app.doh.dc.gov/form/complaint_form.asp

Avoid Medicaid Fraud

Fraud is a big problem in health care... including Medicaid!

The DC Municipal Regulations (DCMR) define fraud as follows:

“Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him or some other person. It includes any act that constitutes fraud under applicable Federal or State law.”

This means saying, doing, or writing something that is not true, so that someone can get something they are not supposed to have (like money) is fraud. People receiving Medicaid services or providers of Medicaid services can be involved in Medicaid fraud.

For example, fraud happens when a doctor or other health care provider:

- Sends a bill to the Medicaid program for a service they did not really give to a patient
- Sends a bill to the Medicaid program for a service that is different from the one they gave the patient, so they can be paid more
- Gives a service the patient did not really need, so they can bill the Medicaid program for it
- Sometimes people who have Medicaid can be involved in fraud too. This can happen when someone who has Medicaid:
 - Allows someone else to use his/her Medicaid card or Medicaid identification number
 - Gets Medicaid by not telling the full truth about things like where they live or how much money they have

- Pretends to need a service so that a health care provider can send a bill to Medicaid and receive payment for the services
- Signs a timesheet for a PCA although the PCA did not show up for work or left early

Sometimes people even offer money to people on Medicaid so they can use their Medicaid identification number. Not only could you lose your Medicaid benefits, you may be legally responsible for fraud.

Fraud hurts many other people, too. When the Medicaid program pays for services and benefits that are not really needed, it does not have the money to pay for care that people really do need. Doctors, dentists or health care aides do not get paid what they deserve because people who are involved in fraud are taking away money that the Medicaid program could use to pay them better. While Medicaid fraud may seem like a “victimless crime,” it is a crime. People who commit Medicaid fraud are stealing from the Medicaid program and the people who depend on it.

If you think you know about some things that may be Medicaid fraud, please report it to the District of Columbia Medicaid Fraud Hotline: (877) 632-2873.